

## Surrogate Decision Making Program Data Form

*To be signed by an Intermediate Care Facility for Individuals with an Intellectual Disability  
or Related Conditions (ICF/IID) Provider Representative*

**Please type or print clearly**

Facility Name		Vendor Number	County	<b>Department Use</b>  <hr style="width: 80%; margin: 0 auto;"/> Case Number (to be assigned by SDM)
Individual's Name				
Age	Date of Birth	Social Security Number	Medicaid Number	
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Ethnicity <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Native American <input type="checkbox"/> Other: _____		
Religion <input type="checkbox"/> Catholic <input type="checkbox"/> Protestant <input type="checkbox"/> Jewish <input type="checkbox"/> Muslim <input type="checkbox"/> Unknown <input type="checkbox"/> None <input type="checkbox"/> Other: _____				
Primary Language		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed		
Method of Communication <input type="checkbox"/> 1. No Functional Means <input type="checkbox"/> 2. Verbal <input type="checkbox"/> 3. Gestural (other than sign) <input type="checkbox"/> 4. American Sign Language <input type="checkbox"/> 5. Signed English <input type="checkbox"/> 6. Other Sign <input type="checkbox"/> 7. Communication Device, describe: _____ <input type="checkbox"/> 8. Written				
Number of Living and Known Relatives Children _____ Siblings _____ Parents _____ Stepparents _____ Other Adult Relatives _____				
Number of Actively Involved Family Members Children _____ Siblings _____ Parents _____ Stepparents _____ Other Adult Relatives _____				
Actively Involved <input type="checkbox"/> Yes <input type="checkbox"/> No				

Complete the Following Sections to Reflect the Individual's Current Status

**Diagnosis**

**Code** – For current medical diagnoses, enter the appropriate code from the International Classification of Diseases-9th Revision-Clinical Modification Manual (ICD-9-CM). Enter the appropriate code from the current Diagnostic and Statistical Manual of Mental Disorders (DMS), for the Psychiatric Diagnoses, if indicated.

**Primary Diagnosis** – Enter the individual's current primary diagnosis (not symptoms) as determined by a physician. Intellectual disability is the primary diagnosis that the individual requires for ICF/IID care. To qualify for an ICF/IID level of care, a related condition must be the primary diagnosis. Although standard medical abbreviations may be used, avoid the abbreviations that may be interpreted for more than one diagnosis.

_____ Primary Diagnosis	_____ ICD-9-CM Code
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**Current Medical Diagnosis** – Enter any other current medical diagnoses that the individual may have as determined by a physician. If more than four diagnoses are present, list those diagnoses that best describe the need for ICF/IID care. Do not enter past diagnoses from which the individual has recovered or the diagnosis indicated on the attached Certification of Need form.

_____ Current Medical Diagnosis	_____ ICD-9-CM Code
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_____ Current Medical Diagnosis	_____ ICD-9-CM Code
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**Psychiatric Diagnoses** – Enter the diagnosis if the individual has any current mental disorder(s) as defined in the current DSM. Leave blank if there is none.

_____ Psychiatric Diagnosis	_____ DSM IIIR/IVTR Code
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_____ Psychiatric Diagnosis	_____ DSM IIIR/IVTR Code
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**Cognitive Functioning**

**IQ** – Enter actual IQ score, if obtainable. If IQ cannot be ascertained for an individual because of the severity of the disability, go to social composite (SC) score.

IQ Score \_\_\_\_\_

**SC** – Enter actual SC number if IQ score is not obtainable due to the severity of the disability. An SC score obtained on the Vineland Social Maturity Scale or other professionally accepted scale is appropriate.

SC Score \_\_\_\_\_

**ABL (Adaptive Behavior Level)** – Indicate appropriate ABL by circling correct response:

- ☐ 1) Mild ABL deficit      ☐ 2) Moderate ABL deficit      ☐ 3) Severe ABL deficit      ☐ 4) Profound ABL deficit

## Level of Care (LOC)

**LOC** – Indicate appropriate LOC by circling correct response:

- ☐ 1) ICF/IID 1      ☐ 2) ICF/IID V      ☐ 3) ICF/IID VI      ☐ 4) ICF/IID VIII

## Functional Assessment

**Complete this section based on the individual's status during the past four weeks and if the behavior/skill was present 60% or more of the time. Indicate the appropriate response by placing a check in the space to the left of the statement that best describes the status.**

**Mobility/Ambulation** – Mobility refers to the ability to move about. Ambulation refers to the ability to walk. Indicate appropriate mobility status.

- ☐ 1. Walks independently; walks with no supervision or physical hands-on assistance. May require mechanical devices (such as cane, crutch or walker) but **not** a wheelchair.
- ☐ 2. Walks with intermittent supervision or physical hands-on assistance for difficult maneuvers (such as for stairs, ramps); may or may **not** require the use of mechanical devices (such as cane, crutch, walker) but, **not** a wheelchair.
- ☐ 3. Walking requires constant supervision and/or physical hands-on assistance (with or without mechanical devices but **not** a wheelchair.
- ☐ 4. Transports self in wheelchair independently; may require intermittent supervision or physical hands-on assistance for difficult maneuvers (such as elevators, ramps, longer distance or transfers); may be able to walk, but generally does **not** walk.
- ☐ 5. Individual is transported in wheelchair or other mobility device; constant supervision and/or physical hands-on assistance is required for all maneuvers.
- ☐ 6. None of the above.

**Complete Creative Ambulation if 6, None of the above, was indicated in Mobility/Ambulation section**

**Creative Ambulation** – Refers to movement by scooting or crawling, etc. Indicate appropriate creative mobility.

- ☐ 0. Does not apply. Individual is ambulatory, transported in a wheelchair, non-mobile, or does not move self.
- ☐ 1. Uses creative mobility independently with **no** supervision or physical hands-on assistance; may require mechanical devices (such as scooter board), but **not** a wheelchair.
- ☐ 2. Uses creative mobility with intermittent supervision or physical hands-on assistance for difficult maneuvers (such as for stairs, ramps); may or may **not** require the use of mechanical devices (such as a scooter board) but **not** a wheelchair.
- ☐ 3. Creative mobility requires constant supervision and/or physical hands-on assistance (with or without mechanical devices).
- ☐ 4. Individual's primary means of mobility is a wheelchair; however, uses creative mobility in familiar settings.

## Sensory/Perceptual Status

Complete this section based on the individual's status during the past four weeks. Indicate the appropriate response by placing a check in the box to the left of the statement that best describes the status.

**Visual Status** – Ability to see in adequate light (with appliances, if used, such as glasses, contact lenses or magnifying glass). This item refers to the individual's functional vision. If an individual has vision in only one eye, double or multiple vision, visual field deficits or disorders of ocular motility, indicate the most accurate description of the person's functional vision (for example, a person who has excellent acuity in a limited field may be considered to have a moderate visual loss). Indicate appropriate status.

- ☐ 1. Sees adequately in all situations, sees fine detail and sees and identifies people and objects in immediate environment (such as their room).
- ☐ 2. Minimal vision loss – sees large print, simple pictures and television; cannot discern detailed text in newspapers or books.
- ☐ 3. Moderate loss – sees fingers at arm's length and obstacles in path; cannot discern newspaper headlines; usually compensates for visual defect by scanning environment.
- ☐ 4. Highly impaired or **no** functional vision – only distinguishes shadows; absence of functional vision (for example, cannot locate objects without hearing or touching them).

**Auditory Status** – This item refers to the individual's functional ability to hear. Indicate the appropriate status.

- ☐ 1. Cannot determine.
- ☐ 2. Hearing within normal limits.
- ☐ 3. Hearing corrected with adaptive device.
- ☐ 4. Hearing impaired even with adaptive device (or cannot tolerate device).
- ☐ 5. No functional hearing.

**Expressive Communication** – This item refers to the individual's functional ability to express and communicate ideas and needs. Indicate appropriate form of expressive communication.

- ☐ 0. No observable impairment.
- ☐ 1. Conversational speech with occasional difficulty in finding words or expressing ideas.
- ☐ 2. Conversational speech with difficulty in expressing long or complex ideas.
- ☐ 3. Consistent expression with gestures or single words and short phrases.
- ☐ 4. Expresses need with single words or gestures that may be ineffective, incomplete or difficult to understand.
- ☐ 5. No functional speech or gestures.

**Receptive Communication** – This item refers to the individual's functional ability to receive and respond to the communication of others. Indicate appropriate form of receptive communication.

- ☐ 0. No observable impairment.
- ☐ 1. Follows conversation with little difficulty.
- ☐ 2. Responds appropriately to simple sentences in verbal or written communication, but may need repetition and may fail to grasp details.
- ☐ 3. Consistently responds to single-word verbal, written or gestural communication.
- ☐ 4. Inconsistently responds (less than 50% of the time) to single-word verbal, written or gestural communication.
- ☐ 5. Does **not** respond appropriately or follow directions in response to repeated verbal, written or gestural communication.